LTC Residents Protection
MAY 21 2009
Director's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085003	A. BUILDING _____ B. WING _____	04/23/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST COUNTRY HOUSE	4830 KENNETT PIKE WILMINGTON, DE 19807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from April 20, 2009 through April 23, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other documentation as indicated. The facility census the first day of the survey was 37. The survey sample totaled ten (10) residents, which included a review of nine (9) active and one (1) closed clinical records.	F 000	Methodist Country House, through our Quality Improvement Programs, continues to provide excellent services to our residents.	
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was	F 279	A. Care plan for resident #6 was completed immediately. See Attachment # 1. B. All other residents were reviewed for presence of pacemakers with care plans. All care plans put in place (2 additional). See Attachment # 2. C. All residents' information will be reviewed on admission for the presence of a pacemaker. When a pacemaker is present, a care plan will be put in place within 3 days. See Attachment # 3. Nurses in the Health Center will be educated by the staff educator to review admissions and put care plans in place for residents with pacemakers. Attachment to be forward when education completed.	6/30/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jan White, NHA — Executive Director — 5-21-09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 determined that the facility failed to ensure that a care plan was developed for 2 out of 10 residents (Resident #6 and #7) that included their pacemakers. Findings include: 1. Resident #6 (R6) was admitted to the facility on 1/22/07. While reviewing the clinical record, a copy of a cardiac pacemaker identification card was found which revealed that R6 had a pacemaker inserted in 2006. Although the resident made his own arrangements for pacemaker checks, the facility failed to have a care plan for the pacemaker, including interventions to monitor functioning of the pacemaker. Findings were confirmed with E4 (unit manager) on 4/22/09 and a care plan was developed on the same date. 2. Resident #7 (R7) was admitted to the facility on 12/18/08. A 3-11 PM shift admission nurse's note stated, "... has pacemaker..." and a 11 PM- 7 AM nurse's note, dated 12/19/08, stated, "... has a pacemaker... left chest...". Although it was known that R7 had a pacemaker, the facility failed to develop a care plan for the pacemaker, including interventions to monitor functioning of the pacemaker. Findings were discussed during the informational meeting on 4/23/09.	F 279	D. An audit for presence of completed care plans for each resident admitted with a pacemaker will be done within 5 days after admission by the ADON or designee to ensure a care plan has been completed. The results will be reviewed starting at the next QI meeting. See Attachment # 4.	
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		

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F 309	Continued From page 2 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the plan of care for 1 out of 10 residents (Resident #5). Resident #5 (R5) was admitted to the facility after sustaining a fall which required surgery for a fractured (broken) hip. She had a history of osteoporosis (thinning of the bones making them more prone to fractures) and a previous fractured arm. Multiple observations were made from 4/20 to 4/22/09 and a fall mat was not present. Findings include: R5 was admitted to the facility on 3/26/09 with diagnoses including end stage dementia, osteoporosis, history of a fractured arm, and a fall on 3/18/09, which resulted in surgical repair of a fractured left hip. Review of the initial MDS (minimum data set) assessment, dated 3/30/09, revealed that R5 had moderate cognitive impairment with short and long-term memory impairment. She was non-ambulatory and required extensive to total staff assistance with all activities of daily living, except eating. The facility developed a care plan for "history and potential for falls r/t (related to) decreased safety awareness and SDAT (senile dementia of the Alzheimer type)" upon admission, on 3/26/09.	F 309	A. The fall mat was immediately put in place at the resident's bed. B. All residents' care plans were reviewed and a bedside audit completed on 4/22/09 to ensure all other residents had mats down as care planned. See Attachment # 5. C. A weekly audit will be done by the Unit Manager or designee to ensure fall mats are in place as care planned. See Attachment # 6. Health Center nurses and aides will be educated by the staff educator to check placement of fall mats per care plans. Attachment to be forwarded when education completed. D. The results of the audit will be given to the DON and ADON weekly to review. See Attachment # 7. The results of the audit will be reviewed starting at the next QI meeting.	6/30/09

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F 309	Continued From page 3 Interventions included, "... low bed with fall mats...". R5 had a fall without injury in the facility one day after she was admitted, on 3/27/09. Multiple observations were made from 4/20/09 to 4/22/09, all of which revealed no fall mat in place. Findings were confirmed with E1 (nurse) and E2 (ADON) on 4/22/09. E1 also confirmed lack of a fall mat in the residents room. E2 stated that the fall mat had been in place during a pre-survey audit. The fall mat was immediately placed after it was brought to the facility's attention.	F 309		
F 329 SS=G	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	A. Resident #10 was a closed record review at the time of survey. B. All present residents who were on Coumadin therapy at that time were reviewed to make sure their Coumadin was given per order, lab tests were performed as ordered, and PT/INRs were reported promptly to the physician. See Attachment # 8. C. An audit will be completed 2x weekly for all residents on Coumadin for administration of Coumadin per physician's order, completion of ordered lab tests and monitoring of PT/INR by the Unit Manager or designee using the Unit Anticoagulant Regiment Audit.	6/30/09

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F 329	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on closed record review, review of hospital documents, and interviews, it was determined that the facility failed to ensure that one (Resident #10) out of 10 sampled residents' drug regimens was free from unnecessary drugs. Resident #10 (R10) was admitted to the facility on 12/10/08 on Coumadin and Aspirin (medications that thin the blood). The facility failed to adequately monitor R10's anticoagulation regimen. Specifically, they failed to administer Coumadin as per physician orders, failed to perform the laboratory (lab) test PT/INR (measures blood coagulation) on 12/26/08 as ordered by the physician and they failed to monitor the PT/INR for 3 weeks until R10 was found unresponsive in the facility on 1/9/09 with rectal bleeding and a dangerously low BP. She was hospitalized on 1/9/09 with an unacceptably high PT/INR level which resulted in repeated episodes of rectal bleeding. R10 received blood transfusions for anemia and FFP (fresh frozen plasma) and Vitamin K to reverse the effects of the Coumadin. She expired in the hospital on 1/20/09 from unrelated causes. Findings include: R10, a 93 year old female, was admitted to the facility on 12/10/08 after a 5 day hospitalization for mental status changes and a UTI (urinary tract infection). She had a history of Alzheimer's disease, a-fib (atrial fibrillation- abnormal heart rhythm with a significantly increased risk of stroke from blood clots), and diverticulosis (weakened outpocketings in the colon wall; most common	F 329	See Attachment # 9. Nurses will be in-serviced on importance and steps to ensure that Coumadin doses administered to the residents are as ordered. Attachment to be forwarded when education completed. The Unit Manager will follow the procedure as outline in Audit Procedure-Actions Needed to complete the Unit Anticoagulant Regimen Audit See Attachment # 10 to obtain the information to complete the audit. D. Results of the audit will be reported weekly to the DON/ADON by the Unit Manager. See Attachment # 11. The results of the audit will be reviewed at the next QI Meetings.	

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F 329	Continued From page 5 symptom bleeding). Review of hospital discharge instructions, dated 12/9/08, included the medications Coumadin 4.5 mg daily, Aspirin 81 mg daily, and Levaquin 250 mg. daily for 5 days (antibiotic for UTI). While R10 was already on 2 medications that thinned the blood (Coumadin and Aspirin) and increased her risk of bleeding, Levaquin additionally had increased effects on Coumadin, with the potential for bleeding. The facility developed a care plan, dated 11/6/08 (although R10 was admitted on 12/10/08), for Coumadin therapy for R10. Interventions included, "... Monitor labs, notify MD of results and adjust meds as ordered...". Anticoagulant Therapy Monitoring Guidelines (http://peir.path.uab.edu) stated that the laboratory monitoring sequence for Coumadin should be done "Daily until INR is therapeutic twice at least 24 hours apart... Twice a week for 2 weeks, then once a month until therapy is complete." A hospital cardiology consultation, dated 12/5/08, revealed that R10 was on Coumadin (to prevent blood clots from a-fib) prior to being hospitalized. She was placed on Heparin (blood thinner) intravenously in the hospital, then switched back to Coumadin. The recommended therapeutic INR range for Coumadin when used for a-fib is 2-3. A PT/INR, done in the hospital on 12/10/08 (day of transfer to the facility), was 18.5 (PT) and 1.7 (INR); subtherapeutic. On 12/11/08, a physician order was written to increase the Coumadin to 5 mg daily. Review of the MAR (medication administration record) revealed that the facility	F 329		

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F 329	Continued From page 6 failed to administer Coumadin on 12/15, 12/16 and 12/17/08. A PT/INR was done on 12/18/08; the INR was 2.23 which was therapeutic. According to a clinical review entitled Risk Management in Long Term Care: Consultive Services on Warfarin Therapy by Pharmacists (www.ascp.com/publications/tcp1996/apr/rmltc.html), "... The therapeutic duration of action of a single dose of warfarin is two to five days...". The PT/INR would have been higher, perhaps out of the therapeutic range had the facility not inadvertently failed to administer Coumadin for 3 days in a row prior to the PT/INR on 12/18/08. Physician orders were written on 12/18/08 to continue Coumadin 5 mg daily and to do another PT/INR on 12/26/08. In the interim, Levaquin was discontinued on 12/12/08 and another antibiotic, Macrobid, was started on 12/16/08, with the same increased effects on Coumadin. Review of a nurse's note, dated 1/9/09, stated, "Called to Rm (sic) Resident unresponsive in bathroom- no response to verbal & tactile (touch) stimuli. BP 48/? palp. (unable to hear; only able to palpate)... 911 called...". R10's admission BP on 12/10/08 was 127/62 (normal). From 12/10/08 to 1/8/09, R10's BP's varied from 88/56 to 163/80. A physician order was written on 1/9/09 to "Send to ER- eval (evaluate) unresponsive episode & rectal bleeding." A gastroenterology consult, dated 1/10/09, stated, "... from a nursing home... usual state of health until one day prior to admission when they noticed some dark red rectal bleeding. This happened several times... patient did complain of diffuse abdominal pain in a crampy-type nature... medications include Coumadin... and aspirin... In the Emergency Room she received packed red	F 329		

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F 329	Continued From page 7 blood cells and fresh frozen plasma... no further bleeding... hemoglobin (component of red blood cells) initially was... down to 9.2 (usual range 11.7-15.7 gm/dL)... prothrombin time was initially quite high... 43.5 seconds (usual range 10-13 seconds), INR 5, however, now it is 15.9 and INR 1.4 ...My impression is that the patient had a lower GI (gastrointestinal) bleed secondary to the elevated prothrombin time (PT)... concerned about the use of Coumadin... recognizing the risk for stroke, however, the risk of bleeding is quite high...". R10 received 4 units of FFP and Vitamin K in the hospital to reverse the effects of the Coumadin. She additionally received 2 units of blood on 1/14/09, when her hemoglobin declined to 8.5. According to www.guideline.gov, the Antithrombotic therapy supplement, "... risk of bleeding for patients on warfarin (Coumadin) increases substantially at INR values greater than 4.0... risk is magnified if one or more risk factors are present... Steady-state INR values will not be realized for up to 3 weeks following a dose adjustment...". R10's Coumadin dose was increased on 12/11/08. A therapeutic level PT/INR was drawn on 12/18/08, however, the facility failed to ensure that the PT/INR ordered to be done on 12/26/08 was done. The facility additionally failed to identify the missed 12/26 PT/INR in their 24 hour chart check, a system designed to double check that all physician orders are properly transcribed and executed. They failed to monitor the PT/INR for 3 weeks until the resident was hospitalized on 1/9/09 with a GI bleed.	F 329		

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F 329	Continued From page 8 A hospital consultation, dated 1/18/09, regarding advanced directives, stated that R10's long-term prognosis was poor, despite insertion of a surgically placed feeding tube into the abdomen. Review of the hospital discharge summary, dated 1/21/09, stated, "Principle Diagnoses 1. Gastrointestinal bleed 2. Atrial fibrillation... Developed a bradyarrhythmia (slow heart rhythm) and coded on January 20, 2009... did not survive...". The death certificate listed the cause of death as arteriosclerotic cardiovascular disease. During an interview with E6 (staff development nurse) on 4/23/09, she stated that PT/INR results are called to the MD, the MD reviews/changes the Coumadin dose and determines the next PT/INR date. E6 stated that all documentation was to be written by nursing on the Anticoagulant Monitor sheet and she stated that the facility lacked a policy for Coumadin monitoring. Review of the monitoring sheet revealed only "12/26 @ (at) hospital." This information was incorrect as R10 was not hospitalized until 1/9/09. Written information was obtained from E7 (DON) post survey and she was interviewed on 4/23/09. She stated, "Our regular lab days are Tuesday and Thursday. Our 3-11 RN supervisor called the lab to see if they were working 12/26/08 and the (name of lab) employee said yes. The RN supervisor noted the order and placed information in the lab book for draw on 12/26/08. Evidently, due to the "odd" day (not being Tuesday or Thursday) the staff did not check the lab book so they were not expecting them. In addition, the lab technician did not show that day... On January 10th 2009 our consultant pharmacist was in to	F 329		

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F 329	Continued From page 9 review charts and notified the Nurse on duty that this lab was not in the chart. The resident was in the hospital at this time of discovery. The nurse went to the lab book to see if it had been drawn and found the form incomplete and it appeared as though the lab was missed... As a result of this omission we put in a Procedure to Ensure Health Care Lab Work is completed per Physician's Orders...". E7 confirmed the missed doses of Coumadin from 12/15 to 12/17/08. She stated that a stop date was inadvertently placed by nursing for the Coumadin when a PT/INR was ordered for 12/15/08 (later changed to 12/18/08). E7 further stated this was not "routine practice". The Coumadin was restarted when the lab results were reviewed with the MD on 12/18/08. The facility failed to administer Coumadin as ordered by the physician and they failed to have a system in place to ensure that laboratory tests were completed as ordered, thus, the facility neglected to obtain the 12/26/08 PT/INR for R10. As a result, the MD was not called, the Coumadin dose was not evaluated to see if a change was needed, and another PT/INR date was not determined. While the facility had forms for Coumadin monitoring, they failed to have an actual policy for monitoring residents' anticoagulation therapy. The facility failed to monitor R10's Coumadin for 3 weeks and consequently, her levels became unacceptably high. R10 developed a GI bleed that required blood transfusions, FFP, and Vitamin K.	F 329		
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	A. Unable to determine if any specific resident was affected. B. Had the potential to affect all residents.	6/30/09

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F 371	Continued From page 10 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations in the dietary department and staff interviews, it was determined that the facility failed to prepare, distribute, and serve food under sanitary conditions. Findings include: 1. Observations of the dishwashing operation in the assisted living service kitchen on 4/20/09 at 1:15 PM revealed that dishes were being cleaned without being sanitized. The warewashing machine sanitized by high temperature rinsing. A thermometer placed in the machine gave a maximum reading of 155 degrees F when it should have reached at least 160 degrees F for proper sanitizing. Interview with the Dietetic Assistant (E3) later that afternoon revealed that a serviceman came and tested the machine and stated that staff had not allowed the machine enough time to warm up before using it. A thermometer was placed in the machine again and read 163 degrees F as the maximum temperature. 2. During a tour of the facility's kitchen on 4/20/09, the faucet on the three-compartment sink was observed to be broken. Dietary staff were not aware that the dishwashing machine needed more time to warm up to reach the proper temperature and therefore were cleaning dishes without sanitizing them.	F 371	C. Staff to be in-serviced on the proper way to make sure machine reaches a temperature at least 160 degrees. Attachment # 12. completed. An audit will be completed each shift by the supervisor to ensure that water temperature is at required levels. See Attachment # 13. D. Dining Services Director or designee will review results of audit weekly. This will also be monitored through monthly QI Meetings. A. Faucet was repaired on 4/23/09 the same day as notification. B. Had potential to affect all residents. C. Daily inspection of kitchen equipment will be conducted by a supervisor. Attachment # 14. Staff to be in-serviced on the importance of reporting broken equipment. Attachment # 15. D. Dining Services Director or designee will review results of audit weekly. Results of the audit will also be monitored through monthly QI meetings.	6/30/09

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F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to have a handwashing sink accessible to staff in the soiled work room. Findings include: Observations in the soiled work room on 4/20/09 and 4/23/09, revealed that a scale was stored in the handwashing sink. The unit manager (E4) confirmed that the scale should not be stored in the sink which should be accessible for staff handwashing.	F 444	A. The scale was removed the day of notification, 4/23/09. B. This had the potential to affect all residents. C. Staff will be educated to keep sink clear for staff use. Attachment # 16. Inspections will be performed by the Environmental Manager and documented on a bi-weekly inspection report beginning 4/20/09. See Attachment # 17. The Environmental Manager will report the results of the inspections to the Director of General Services weekly. D. This procedure will be monitored through monthly QI meetings.	6/30/09
F 445 SS=E	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined that the facility failed to handle and store linens to prevent the spread of infection. Findings include: Observations were made in the laundry area of the facility on 4/21/09 at 1:50 PM. 1. The door to the soiled laundry room was left	F 445	A. Self closing hinges will be ordered and installed on the doors; this action will be complete by 5/18/09. B. This practice had potential to affect all residents C. Inspections will be performed by the Manager of Environmental Services and documented on a bi-weekly inspection report beginning 4/20/09. Attachment # 18. The Environmental Manager will report the results of the inspection to the Director of General Services weekly.	6/30/09

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085003	A. BUILDING _____ B. WING _____	04/23/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST COUNTRY HOUSE	4830 KENNETT PIKE WILMINGTON, DE 19807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 445	Continued From page 12 partially opened. 2. A large open bin of soiled towels was observed in the hallway outside of the laundry room. The housekeeping director (E5) confirmed that the door to the soiled laundry room should have been closed and the bin of soiled towels should have been covered.	F 445	D. This procedure will be monitored through monthly QI meetings A. A cover for the bin exists and was installed the same day as the notification; 4/23/09. B. This procedure had the potential to affect all residents. C. Laundry and Housekeeping staff were re-educated 4/28/09 on the critical nature of this procedure. An in-service tracking sheet has been formulated. See Attachment # 19. Weekly inspections will be performed by the Manager of Environmental Services and documented on a formal inspection report. See Attachment # 20. The Environmental Manager will report results of the inspections to the Director of General Services. D. This procedure will be monitored through monthly QI meetings.	6/30/09

DELAWARE HEALTH
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DHSS - DLTCRP
3 Mill Road, Suite 308
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(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Methodist Country House

DATE SURVEY COMPLETED: April 23, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility from April 20, 2009 through April 23, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other documentation as indicated. The facility census the first day of the survey was 37. The survey sample totaled ten (10) residents, which included a review of nine (9) active and one (1) closed clinical records.	F Tag 309 A. The fall mat was immediately put in place at the resident's bed. B. All residents' care plans were reviewed and a bedside audit completed on 4/22/09 to ensure all other residents had mats down as care planned. See Attachment # 5. C. A weekly audit will be done by the Unit Manager or designee to ensure fall mats are in place as care. See Attachment # 6. Health Center nurses and aides will be educated by the staff educator to check placement of fall mats per care plans. Attachment to be forwarded when education completed. D. The results of the audit will be given to the DON and ADON weekly to review. See Attachment # 7. The results of the audit will be reviewed starting at the next QI meeting. Completion Date 6/30/09
3201	**Skilled and Intermediate Facilities**	
3201. 6.0	**Services to Residents**	
3201.6.1	**General Services**	
3201.6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 4/23/09, F309 and F329.	

Provider's Signature _____ Title _____ Date _____

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility from April 20, 2009 through April 23, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other documentation as indicated. The facility census the first day of the survey was 37. The survey sample totaled ten (10) residents, which included a review of nine (9) active and one (1) closed clinical records.	F Tag 329 A. Resident #10 was a closed record review at the time of survey. B. All present residents who were on Coumadin therapy at that time were reviewed to make sure their Coumadin was given per order, lab tests were performed as ordered, and PT/INRs were reported promptly to the physician. See Attachment # 8. C. An audit will be completed 2x weekly for all residents on Coumadin for administration of Coumadin per physician's order, completion of ordered lab tests and monitoring of PT/INR by the Unit Manager or designee using the Unit Anticoagulant Regiment Audit. See Attachment # 9. Nurses will be in-serviced on importance and steps to ensure that Coumadin doses administered to the residents are as ordered. Attachment to be forwarded when education completed. The Unit Manager will follow the Audit Procedure-actions needed to complete the Unit Anticoagulant Regimen Audit. See Attachment # 10 to obtain the information to complete the audit. D. Results of the audit will be reported weekly to the DON/ADON by the Unit Manager. See Attachment # 11. The results of the audit will be reviewed at the next QI Meeting. Completion Date 6/30/09
3201	**Skilled and Intermediate Facilities**	
3201. 6.0	**Services to Residents**	
3201.6.1	**General Services**	
3201.6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 4/23/09, F309 and F329.	

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.5	**Nursing Administration**	F Tag 279 A. Care plan for resident #6 was completed immediately. See Attachment # 1. B. All other residents were reviewed for presence of pacemakers with care plans. All care plans put in place (2 additional). See Attachment # 2. C. All residents' information will be reviewed on admission for the presence of a pacemaker. When a pacemaker is present, a care plan will be put in place within 3 days. See Attachment # 3. Nurses in the Health Center will be educated by the staff educator to review admissions and put care plans in place for residents with pacemakers. Attachment to be forward when education completed. D. An audit for presence of completed of care plans for each resident admitted with a pacemaker will be done within 5 days after admission by the ADON or designee to ensure a care plan has been completed. The results will be reviewed starting at the next QI meeting. See Attachment # 4. Completion Date 6/30/09
3201.6.5.3	**Within 14 days of admission, the facility shall make a comprehensive assessment of each resident's needs. This assessment shall include, at a minimum, the following information:**	
3201. 6.5.3.15	**Special treatments and procedures** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 4/23/09, F279.	
3201.6.9	**Housekeeping and Laundry Services**	
3201.6.9.5	**The facility's handling, storage, processing and transporting of linens shall comply with facility infection control policies and procedures.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 4/23/09, F445, example #1.	
3201.7.0	**Plant, Equipment and Physical Environment**	
3201. 7.5	**Kitchen and Food Storage Areas**	

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.5	**Nursing Administration**	F Tag 445 #1 A. Self closing hinges will be ordered and installed on the doors; this action will be complete by 5/18/09. B. This practice had potential to affect all residents C. Inspections will be performed by the Manager of Environmental Services and documented on a bi-weekly inspection report beginning 4/20/09. Attachment # 18. The Environmental Manager will report the results of the inspection to the Director of General Services weekly. D. This procedure will be monitored through monthly QI meeting. Completion Date 6\30\09
3201.6.5.3	**Within 14 days of admission, the facility shall make a comprehensive assessment of each resident's needs. This assessment shall include, at a minimum, the following information:**	
3201. 6.5.3.15	**Special treatments and procedures** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 4/23/09, F279.	
3201.6.9	**Housekeeping and Laundry Services**	
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3201.7.0	**Plant, Equipment and Physical Environment**	
3201. 7.5	Kitchen and Food Storage Areas	

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3201.7.5.1	**Facilities shall comply with the Delaware Food Code.** **This requirement is not met as evidenced by:** Based on dietary observations on 4/23/2009, it was determined that the facility failed to comply with sections 4-702.11 and 5-205.15 (B) of the Delaware Food Code. Findings include: **4-702.11 Before Use After Cleaning.** **Utensils and food-contact surfaces of equipment shall be sanitized before use after cleaning.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 4/23/09, F371, example #2. **5-205.15 System Maintained in Good Repair** **A plumbing system shall be:** **(B) Maintained in good repair.** **This requirement is not met as evidenced by:**	A. Faucet was repaired on 4/23/09 the same day as notification. B. Had potential to affect all residents. C. Daily inspection of kitchen equipment will be conducted by a supervisor. Attachment # 14. Staff to be in-serviced on the importance of reporting broken equipment. Attachment # 15. D. Dining Services Director or designee will review results of audit weekly. Results of the audit will also be monitored through monthly QI meetings. Completion Date 6/30/09

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	Cross refer to CMS 2567-L survey date completed 4/23/09, F371, example #1.	F Tag 371 #1 A. Unable to determine if any specific resident was affected. B. Had the potential to affect all residents. C. Staff to be in-serviced on the proper way to make sure machine reaches a temperature at least 160 degrees. Attachment # 12 . An audit will be completed each shift by the supervisor to ensure that water temperature is at required levels. See Attachment # 13 . D. Dining Services Director or designee will review results of audit weekly. This will also be monitored through monthly QI Meetings. Completion Date 6/30/09
3201.7.6 3201.7.6.4 3201.7.6.4.2	**Sanitation and Laundry** **For off-site laundry processing, the facility shall:** **Provide a soiled linen holding room (or a designated area in the soiled utility room) under negative air pressure for the storage of soiled linen.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 4/23/09, F445, example #2.	
3201. 7.6.5	**The facility shall have a soiled utility room under negative pressure for storage of infectious waste and for disposal of body fluids. The room shall have a work counter, hand washing sink, and clinical sink or other bed pan cleaning device.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed	

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	Cross refer to CMS 2567-L survey date completed 4/23/09, F371, example #1.	F Tag 445 #2 A. A cover for the bin exists and was installed the same day as the notification; 4/23/09. B. This procedure had the potential to affect all residents. C. Laundry and Housekeeping staff were re-educated 4/28/09 on the critical nature of this procedure. An in-service tracking sheet has been formulated. See Attachment # 19. Weekly inspections will be performed by the Manager of Environmental Services and documented on a formal inspection report. See Attachment # 20. The Environmental Manager will report results of the inspections to the Director of General Services. D. This procedure will be monitored through monthly QI meetings Completion Date 6/30/09
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	4/23/09, F444.	A. The scale was removed the day of notification, 4/23/09. B. This had the potential to affect all residents. C. Staff will be educated to keep sink clear for staff use. Attachment # 16. Inspections will be performed by the Environmental Manager and documented on a bi-weekly inspection report beginning 4/20/09. See Attachment # 17. The Environmental Manager will report the results of the inspections to the Director of General Services weekly. D. This procedure will be monitored through monthly QI meetings Completion Date 10/30/09